MEDICATION RECONCILIATION

I. PURPOSE: To establish a consistent process to completely and accurately reconcile Veteran medications across the continuum of care at VA Butler Healthcare.

II. POLICY: VA Butler Healthcare will provide well-coordinated, safe, and effective patient-centered care as it pertains to the management of Veteran medication information. Whenever a Veteran moves from one provider or level of care, within or outside of VA Butler Healthcare, to another provider of care, the complete and reconciled current list of that Veteran's medications, allergies, and adverse reactions will be made available to the Veteran and/or next provider of care to be compared and reconciled with the medications provided by that next provider. This process actively involves the Veteran and/or the Veteran's healthcare surrogate in their shared responsibility for informing healthcare providers regarding the Veteran's medication use.

III. DEFINITIONS:

A. Medication Reconciliation: A process to ensure maintenance of complete, accurate, safe, and effective patient-centered medication treatments and medication information by:

1. obtaining medication information from the Veteran or caregiver

2. comparing and reconciling the information obtained from the Veteran or caregiver with the medication information available in the VA electronic medical record in order to identify and address discrepancies

3. documenting the most up to date medication information in the VA electronic medical record

4. communicating with and providing education to the Veteran or caregiver regarding updated medication information

5. communicating relevant medication information among appropriate members of the VA and non-VA healthcare team

B. VA Providers: VA providers are physicians, dentists, advanced practice nurses, physician assistants, clinical nurse specialists, clinical pharmacists, clinical pharmacy specialists, and other healthcare professionals who provide primary care or specialty care within the limitations of their individual VA privileges or scopes of practice.

C. Non-VA Providers: Non-VA providers are community providers including physicians, dentists, advanced practice nurses, physician assistants, and other healthcare professionals who provide healthcare to Veteran patients outside of VA. This includes services reimbursed by Fee-Basis/Non-VA Care, Department of Defense, Tricare, Medicare, private pay, and health insurance. Examples of methods to communicate with non-VA providers include verbal telephone conversations, electronic telephone facsimile, and correspondence by mail, in compliance with patient privacy regulations and local policies.

D. VA Medications: VA medications are medications ordered and dispensed locally at the treating VA facility.

E. Non-VA Medications: Examples of non-VA medications include non-VA provider prescribed medications filled at non-VA pharmacies; VA provider prescribed medication filled at non-VA pharmacies; and herbals, over-the counter-medications, nutraceuticals, and alternative medications procured by Veterans from non-VA sources.

F. Remote VA Medications: Remote VA medications are medications ordered at any other VA facility (viewed or imported via remote data view in CPRS) apart from the local, treating facility.

G. Veterans Receiving Dual Care: Veterans receiving dual care refers to Veterans who receive ongoing and concurrent healthcare in both the VA and non-VA settings.

IV. RESPONSIBILITIES

A. The Director must ensure medication reconciliation processes are established, standardized, maintained, and monitored through the Facility Medication Reconciliation Point of Contact (POC).

B. The Facility Medication Reconciliation POC is responsible for:

1. Receiving and disseminating new knowledge and information of medication reconciliation transferred from the VISN Medication Reconciliation POC.

2. Ensuring that local policies conform to the critical quality and safety elements defined in VHA Directive 2011-012 Medication Reconciliation and guidance of accrediting bodies.

3. Monitoring the medication reconciliation process and reporting metrics including, but not limited to:

a. Distribution of medication lists to Veterans

b. Documentation of medication reconciliation at each Veteran-provider encounter

c. Verification of the quality of medication reconciliation documentation

C. The medication reconciliation process is a shared responsibility between Veterans, their providers, and the healthcare team support staff.

D. VA Providers are responsible for:

1. The completion of medication reconciliation at every episode of care or transition in level of care where medications will be prescribed, modified, or may in anyway influence the care given, in accordance with this policy and VHA Directive 2011-012. This includes the reconciliation of medications prescribed through or procured outside of the VA system, in order

to prevent medication errors and to diminish potential safety risks associated with patient dual care.

2. Documenting actions (e.g., drug regimen changes, monitoring, etc.) that address medication discrepancies. The documented action or plan of action will be commensurate with the severity of the discrepancy and the risk of Veteran harm.

3. Documenting allergies, adverse events, and close calls/potential medication errors. All adverse drug events and allergies must be entered into the Computerized Patient Record System (CPRS). Close calls/potential medication errors will be entered into the facility's potential medication error tracking system.

4. Providing written and oral medication information in the course of their encounters with Veterans.

5. Educating Veterans involved in dual care as defined by VHA's National Dual Care Policy (2009-038) and Medical Center Memorandum PC-50 Dual Care Policy.

6. Assisting the Veteran or caregiver to maintain, update, and take ownership of the Veteran's medication information. At every opportunity, Veterans should be encouraged and educated to actively participate in the decision making process for their treatment plan. As part of their shared responsibility, the Veteran or caregiver should be encouraged to share with the Veteran's healthcare team:

a. The Veteran's goals of care;

b. Medication utilization;

c. Problems that affect medication adherence, such as:

(1) Allergies and/or adverse drug reactions (ADRs),

(2) Difficulties with access to healthcare,

(3) Financial hardship,

(4) Recommended medication treatment plan declined, or

(5) Other health-system, condition, or therapy-related factors;

d. Non-VA medication and Non-VA provider information;

e. Any medication and provider information from other (i.e., remote) VA facilities;

f. The Veteran's healthcare proxy, if there is one.

E. Support members of the healthcare team are responsible for:

1. Applying the unique skill set of their respective discipline to aid in reconciling Veterans' medication regimens and providing written and oral medication information in the course of their encounters with Veterans.

2. Assisting VA and non-VA providers by communicating Veteran medication information, in compliance with patient privacy regulations and local policies.

3. Documenting any changes or discrepancies in Veteran medication information discovered in communications with Veterans or caregivers, or non-VA providers and informing the VA provider of these differences.

4. Documenting and reporting allergies, adverse events, and close calls/potential medication errors, as appropriate per job duties.

5. Providing support in reconciling Veteran medications per area of content expertise or applicable job duties through referral by the treating VA provider (e.g., clinical pharmacists, dieticians, etc.).

6. Notifying the VA provider if medication-related issues arise that are outside the scope of the support staff member's scope of care.

7. Assisting the Veteran or caregiver to maintain, update, and take ownership of the Veteran's medication information. At every opportunity, Veterans should be encouraged and educated to actively participate in the decision making process for their treatment plan. As part of their shared responsibility, the Veteran or caregiver should be encouraged to share with the Veteran's healthcare team:

a. The Veteran's goals of care;

b. Medication utilization;

c. Problems that affect medication adherence, such as:

(1) Allergies and/or ADRs,

(2) Difficulties with access to healthcare,

(3) Financial hardship,

(4) Recommended medication treatment plan declined, or

(5) Other health-system, condition, or therapy-related factors;

d. Non-VA medication and Non-VA provider information;

e. Any medication and provider information from other (i.e., remote) VA facilities;

f. The Veteran's healthcare proxy, if there is one.

V. PROCEDURES:

A. Medication Reconciliation is required to be completed at every episode of care with a provider or transition in level of care where medications will be prescribed, modified, or may in anyway influence the care given. Only in emergency circumstances, when the medication reconciliation process would detrimentally delay patient care, may it be omitted.

B. Ambulatory Care/Primary Care:

1. Ambulatory/Primary Care encounters occur in the following areas:

a. Primary Care Clinics;

b. Community-Based Outpatient Clinics;

2. Medical Support Assistants (MSAs) or other administrative personnel will pre-print Veteran medication lists from the information in the CPRS electronic medical record for all Veterans scheduled for clinic visits prior to the start of each business day. Any unscheduled Veterans must have medication lists printed at the time of scheduling for a same-day appointment.

3. MSAs will provide Medication Lists for the Veteran to review with his/her provider or the clinical staff member rendering care at that encounter.

4. The provider delivering care at a particular visit where medications will be prescribed, modified, or may in anyway influence the care given will, within the scope of their practice or subspecialty:

a. Interview Veterans or caregivers to obtain up to date medication regimen information, in oral or written/print format, including both scheduled and as-needed medications from VA and non-VA sources.

b. Compare the Veteran's incoming medication regimen against the documented medication regimen in the Veteran's electronic health record contained in CPRS, including medications from remote VA facilities.

c. Appropriately document all discrepancies (including omissions, duplications, contraindications, and unclear information/changes) via a progress note or chart update in the Veteran's electronic health record:

(1) Verify and update known medication allergies and adverse reactions

(2) Document signs of non-compliance with prescribed medication therapies

(3) Medical staff, physician assistants, advanced practice nurses, pharmacists, and

nurses in provider roles will:

(a) Discontinue VA medications that the Veteran is no longer taking

(b) Enter VA medication orders to reflect the most current name, strength, dosage, route, frequency, and purpose of use of VA medications that the Veteran is taking

(c) Update (i.e., add/change/discontinue) the Veteran's current regimen of non-VA medications

(d) If prescribing medications or modifying the medication regimen, per Scope of Practice or clinical privileges, explicitly document new, changed, or discontinued medications in a progress note as reflected by the most current drug regimen in the patient chart.

d. At the completion of a Veteran encounter, provide the Veteran or caregiver with an up to date list of medications including name, strength, dosage, route, frequency, and purpose of use for VA medications, remote VA medications, and non-VA medications. Recently expired medications may also be listed as a separate section, if appropriate.

e. Instruct the Veteran or caregiver to provide the list of medications to the Veteran's next provider of care and to notify their VA provider of any changes to their medication regimen (including herbals, over-the counter-medications, nutraceuticals, and alternative medications) occurring before their next encounter with VA clinical staff.

f. If the Veteran is at a remote location, apart from the provider of care (e.g., PACT telephone visit, telehealth visit, etc.), the medication list will be mailed to the Veteran's home address.

5. Non-provider support team members will:

a. Notify the ordering provider of VA and non-VA medications that the Veteran is no longer taking (i.e., to discontinue)

b. Notify the ordering provider of reported new or changed VA and non-VA medications that the Veteran is taking including the name, strength, dosage, route, frequency, and purpose of use.

6. The pharmacist will:

a. Be consulted, as needed to assess issues with the Veteran's medication regimen

b. Verify the appropriateness of medication orders and the medication regimen for the Veteran's conditions, notifying medical staff of discrepancies or inappropriateness in prescribed treatments.

B. Ambulatory Care/Specialty Care:

1. Ambulatory/Specialty Care encounters occur in the following medical center areas and associated CBOCs:

a. Center for Behavioral Healthcare;

b. Specialty Clinics

c. Dental Clinic;

d. Cardiopulmonary Clinic;

e. Rehabilitation Services;

f. Pharmacy Medication Management Clinics;

2. The same procedures for performing medication reconciliation in the Ambulatory Care/Primary Care area would apply within each specialty care areas, to the extent of each provider's respective expertise.

3. In the event a provider in a specialty care area identifies a discrepancy in the patient's medication regimen which is outside of their area of expertise, the primary care team should be notified to follow-up and address the discrepancy to ensure accuracy of the patient's active medication list as documented in the VA electronic medical record.

D. Ambulatory Care for Traveling Veterans

1. To coordinate care for Veterans who primarily receive care under the authority of another VA facility, who are seeking a bridge supply of medication from Butler VA Healthcare while they are away from their home facility, the procedures of MCM MM-18 Traveling Veterans should be followed.

2. Per MCM MM-18, for Veteran requests that can be handled by a pharmacist, a pharmacist will interview the Veteran or caregiver to obtain up to date medication regimen information, in oral or written/print format, including both scheduled and as-needed medications, from VA and non-VA sources, to compare against the medication regimen information stored in the remote computer system of the Veteran's home VA facility and any other VA facilities.

3. All discrepancies should be documented (including omissions, duplications, contraindications, unclear information, and changes) via a progress note in the Veteran's electronic health record at Butler VA Healthcare.

4. If discrepancies involve a medication for which the Veteran has requested a bridge supply, per MCM MM-18, the Veteran will be referred to the appropriate ambulatory care clinic for evaluation; the medication reconciliation procedures for Ambulatory Care listed in this policy should be followed.

5. If discrepancies involve medications for which a bridge supply has not been

requested, the pharmacist will document the discrepancies in a progress note and annotate this information on the Veteran's medication list so that they can discuss these issues with clinical staff from their home facility.

6. Veterans will be provided with an up to date list of medications including name, strength, dosage, route, frequency, and purpose of use for bridge supplies of medications dispensed from VA Butler Healthcare, remote VA medications from the Veteran's home facility, and non-VA medications.

7. Per MCM MM-18, for requests that cannot be handled by a pharmacist (i.e., precluded medications), the Veteran should be referred to an appropriate ambulatory care clinic and the medication reconciliation procedures for Ambulatory Care listed in this policy should be followed.

E. Residential Behavioral Health

1. The following medical center areas provide residential behavioral health services:

a. Mental Health Residential Rehabilitation Treatment Program (MHRRTP)

(1) Domiciliary Residential Rehabilitation Treatment Program (DRRTP)

(2) Compensated Work Therapy-Transitional Residence (CWT-TR)

2. Admission to MHRRTP:

a. On admission to the MHRRTP program, nursing staff will:

(1) Interview the Veteran or caregiver to obtain up to date medication regimen information, in oral or written/print format, including both scheduled and as-needed medications from VA and non-VA sources.

(2) Interview the Veteran or caregiver to obtain up to date information regarding Veteran drug allergies and adverse reactions.

b. Disposal of outside medications:

(1) All medications brought with the Veteran will be sequestered and inventoried.

(2) The inventory should be brief, listing the name of the medication and the strength.

(3) For controlled substances, nursing staff should count the number of units of the controlled substance and document the name, strength, and quantity of the medication. Controlled substances should be secured in a locked area until they can be transferred to the Police Service for destruction.

(4) All sequestered non-controlled medications should be returned to the pharmacy with the associated inventory sheet.

c. The MHRRTP provider will:

(1) Interview Veterans or caregivers to obtain up to date medication regimen information, in oral or written/print format, including both scheduled and as-needed medications from VA and non-VA sources.

(2) Compare the Veteran's medication regimen against the documented medication regimen in the Veteran's electronic health record contained in CPRS, including medications at remote VA facilities.

(3) Appropriately document all discrepancies (including omissions, duplications, contraindications, unclear information, and changes) via a progress note or chart update in the Veteran's electronic health record:

(a) Verify the Veteran's current regimen of non-VA medications and order them as VA medications and/or discontinue them as appropriate.

(b) Verify and update known medication allergies and adverse reactions.

(c) Document signs of non-compliance with prescribed medication therapies.

(d) Discontinue VA medications that the Veteran is no longer taking.

(e) Enter VA medication orders to reflect the most current name, strength, dosage, route, frequency, and purpose of use of VA medications that the Veteran is taking.

(f) After conducting the evaluation, explicitly document new, changed, or discontinued medications in a progress note as reflected by the most current drug regimen in the Veteran's chart.

d. The designated pharmacist will:

(1) Verify and update known medication allergies and adverse reactions.

(2) Compare the Veteran's admission medication orders against the documented medication regimen in the Veteran's electronic health record contained in CPRS.

(3) Notify the provider if discrepancies (including omissions, duplications, contraindications, and unclear information and changes) are found.

(4) Counsel the Veteran and provide a list of admission medications including name, strength, dosage, route, frequency, and purpose of use.

(5) Process medication orders, as appropriate.

(6) Provide the Veteran with their list of active medications including name, strength, dosage, route, frequency, and purpose of use.

3. Veterans enrolled in the MHRRTP program should have no active prescription medications at remote VA facilities or from non-VA sources. All medication orders must go through the MHRRTP provider (i.e., the Veteran's primary provider of care in MHRRTP).

4. If the Veteran has active medication orders at remote VA facilities, the designated pharmacist will contact the remote VA pharmacy to discontinue the Veteran's remote medications.

5. Episodic MHRRTP care

a. Episodic MHRRTP care (e.g., outpatient enocunters for patients admitted to this program) will follow the medication reconciliation procedures for Ambulatory Care listed in this policy.

6. Discharge from MHRRTP

a. Prior to discharge, the MHRRTP provider will:

(1) Review the Veteran's medication orders to determine the discharge regimen.

(2) Communicate medication regimen to the Veteran.

(3) Provide written and/or print medication discharge instructions that include an accurate list of VA-provided discharge medications and medications to be purchased over-the-counter.

b. The MHRRTP provider will issue discharge medication orders with no refills

c. The designated pharmacist will:

(1) Verify and update known medication allergies and adverse.

(2) Compare the Veteran's discharge medication orders against the documented medication regimen in the Veteran's electronic health record contained in CPRS.

(3) Notify the provider if discrepancies (including omissions, duplications, contraindications, and unclear information and changes) are found.

(4) Counsel the Veteran and provide a list of discharge medications including name, strength, dosage, route, frequency, and purpose of use.

(5) Process medication orders, as appropriate.

(6) Document the medication regimen review and reconciliation in a progress

note.

(7) Provide the Veteran with a medication list containing all scheduled and as-needed discharge medications including name, strength, dosage, route, frequency, and purpose of use. Recently expired medications may be listed separately, if appropriate.

(8) Instruct the Veteran or caregiver to provide the list of medications to the Veteran's next provider of care and to note any changes to their medication regimen (including herbals, over-the-counter medications, nutraceuticals, and alternative medications) that may occur before their next scheduled visit with their next provider of care.

F. Home Care:

1. The following medical center areas provide home care services:

a. Home-Based Primary Care

2. On admission, nursing staff will:

a. Interview the Veteran or caregiver to obtain up to date medication regimen information, in oral or written/print format, including both scheduled and as-needed medications from VA and non-VA sources.

b. Interview the Veteran or caregiver to obtain up to date information regarding Veteran drug allergies and adverse reactions.

3. On admission, the provider will:

a. Compare the Veteran's medication regimen obtained by nursing staff against the documented medication regimen in the Veteran's electronic health record contained in CPRS, including medications from remote VA facilities.

b. Appropriately document all discrepancies (including omissions, duplications, contraindications, unclear information, and changes) via a progress note or chart update in the Veteran's electronic health record.

c. Document signs of non-compliance with prescribed medication therapies.

d. Verify the Veteran's current regimen of non-VA medications and update (i.e., add/change/discontinue) as appropriate.

e. Discontinue VA medications that the Veteran is no longer taking.

f. Enter VA medication orders to reflect the most current name, strength, dosage, route, frequency, and purpose of use of VA medications that the Veteran is taking.

g. Verify and update known medication allergies and adverse reactions.

h. After conducting a patient evaluation, explicitly document new, changed, or discontinued medications in a progress note as reflected by the most current drug regimen in the patient chart.

4. Within the first 30 days of admission, the designated pharmacist will:

a. Document a review of the Veteran's medication regimen, including both scheduled and as-needed medications from VA and non-VA providers:

(1) Compare the Veteran's medication orders against the list of medications provided upon admission.

(2) Verify the Veteran's current regimen of non-VA medications and update (i.e., add/change/discontinue) as appropriate.

(3) Verify and update known medication allergies and adverse reactions.

(4) Review appropriate laboratory monitoring parameters.

(5) All documentation should include medication name, dose, route, frequency, purpose of use, and duration, if applicable.

b. The pharmacist will notify the provider via electronic co-signature of all discrepancies (including omissions, duplications, contraindications, and unclear information and changes) and other pertinent information.

5. Episodic care (e.g., home visits):

a. At each home visit, the nurse will:

(1) Give the Veteran or caregiver an up to date medication list including both scheduled and as-needed medications containing medication name, dose, route, frequency, purpose of use, and duration, if applicable. Recently expired medications may be listed separately, if appropriate.

(2) Review the Veteran's medication list with the Veteran to verify its accuracy.

(3) Annotate on the Veteran's medication list any changes/differences so that it reflects the Veteran's most current medication regimen.

(4) Instruct the Veteran or caregiver to provide the list of medications to the Veteran's next provider of care and to notify their VA provider of any changes to their medication regimen (including herbals, over-the counter-medications, nutraceuticals, and alternative medications) occurring before their next encounter with VA clinical staff.

(5) Notify the provider and pharmacist of any changes in the Veteran's medications regimen by identifying them as signers to a progress note in CPRS.

b. The provider will compare the nurse's findings with the electronic medication regimen and document discrepancies (including omissions, duplications, contraindications, and unclear information and changes) in a progress note.

c. The provider will modify the electronic medication regimen, as warranted, to reflect the most current information including updating non-VA medications.

d. The designated pharmacist will:

(1) Be consulted, as needed, by nursing and medical staff to assess issues with the Veteran's medication regimen.

(2) Verify the appropriateness of medication orders and the medication regimen for the Veteran's conditions, notifying home care medical staff of discrepancies or inappropriateness in prescribed treatments.

(3) Conduct and document quarterly medication regimen reviews for each Veteran enrolled in the Home Care program that are to be presented as part of the multidisciplinary Home-Based Primary Care treatment team meetings.

(4) Conduct and document a medication regimen review for each Veteran enrolled in the Home Care program that suffers a fall and do this for each instance of a fall so that this information may also be presented as part of the multidisciplinary Home-Based Primary Care treatment team meetings.

6. Discharge Procedure

a. Veterans discharged from Home-Based Primary Care to another level of VA care will be followed as designated per the respective areas listed in this policy.

b. After a period of two weeks, Veterans admitted to non-VA care will be discharged from the Home-Based Primary Care program. If Veterans are admitted directly from home to a facility other than VA Butler Healthcare, the Veteran's VA issued medication list should serve as the primary reference for non-VA providers. Upon request, the Home-Based Primary Care provider or VA Release of Information (ROI) Service will provide non-VA providers with additional information verbally via telephone, by electronic telephone facsimile, or through correspondence by mail, in compliance with patient privacy regulations and local policies.

G. Long-Term Care

1. The following areas provide long-term care services:

a. Community Living Center

(1) Halls of Honor

(2) Village of Valor

2. Admission/Readmission:

a. Screening Procedure:

(1) Prior to admission, the RN Case Manager will obtain documentation of the Veteran's current medication regimen from both VA and non-VA sources (including herbals, over-the counter-medications, nutraceuticals, and alternative medications).

(2) The RN Case Manager, will provide a scanned/electronic copy of the medication regimen on a shared network folder that will be available to the admitting provider, patient care staff on the admitting nursing unit, and Pharmacy Service.

b. On Admission:

(1) Nursing staff will obtain any additional paperwork or information detailing the resident's medication regimen coming with the Veteran and electronically scan the information to the network folder so that it may be accessed by all appropriate staff across disciplines.

(2) For any medications that may be brought with the resident to the facility during the admission process:

(a) Nursing staff, in consultation with pharmacy staff, will use their clinical judgment to assess the potential for polypharmacy upon discharge (i.e., balancing excessive accumulation of medications at the resident's home with the prudent use of previously dispensed medications) if medications are to be returned to the resident.

(b) Medications that are determined to be best disposed of shall be briefly inventoried (generic name and strength only) on an inventory sheet by nursing staff and held for return to pharmacy.

(c) For controlled substances, nursing staff should count the number of units of the controlled substance and document the name, strength, and quantity of the medication. Controlled substances should be secured in a locked area until they can be transferred to the Police Service for destruction.

(d) If it is determined that the medications should not be destroyed (e.g., short stay or respite residents who should not need to have orders re-written), every effort should be made to return the medications with the resident's caregiver to the resident's home.

(e) If medications are not able to be sent back to the resident's home with a caregiver, and it is determined that they should not be disposed of, the medications should be inventoried by nursing staff as above and the inventory sheet should indicate that pharmacy is requested to store these medications until the resident is discharged. However, controlled substances cannot be stored by pharmacy and would be required to be transferred to the Police

Service for destruction.

(3) The provider should receive copies of any inventory sheets as well as copies of any medical documentation transferred with the resident or during the admission pre-screening.

(4) The provider will interview the resident to verify medication regimen documentation.

(5) The provider will compare the resident's incoming medication regimen against the documented medication regimen in the resident's electronic health record contained in CPRS, including medications at remote VA facilities and document this review within 48 hours of resident admission.

(6) The provider will document all discrepancies (including omissions, duplications, contraindications, and unclear information/changes) via a progress note or chart update in the resident's electronic health record.

(7) The provider will place medication orders, as appropriate, and document medications ordered upon admission, including medication name, dose, route, frequency, purpose of use, and duration, if applicable, via a progress note and chart update in the resident's electronic health record.

(8) Within 72 hours of admission, the pharmacist will conduct an in-depth review document the resident's drug regimen including a comparison of the medication regimen upon admission (i.e., current medication orders) with the resident's admission documentation.

(a) Both scheduled and as-needed medications should be documented and reviewed.

(b) Documented information should include medication name, dose, route, frequency, purpose of use, and duration, if applicable.

(9) The pharmacist will notify the provider of any discrepancies (including omissions, duplications, contraindications, and unclear information and changes)

3. Long-Term Stays (>1 month)

a. The pharmacist will conduct monthly drug regimen reviews to reconcile medications for each resident on nursing units.

b. Documented information should include medication name, dose, route, frequency, purpose of use, and duration, if applicable.

c. The pharmacist will notify the provider if discrepancies (including omissions, duplications, contraindications, therapeutic and unclear information and changes) are noted.

4. Intrafacility Transfer:

a. Intrafacility transfers do not necessitate discontinuation of medication orders. In the event that all medication orders for the resident are discontinued, by provider clinical judgment or in error, the admission/readmission procedures should be followed upon the resident's transfer to the receiving nursing unit. At no time are orders permitted to be blanket reinstated.

b. Nursing staff on the transferring unit should notify the pharmacy via transfer sheet (e.g., facsimile copy) of a resident being transferred between units.

c. The inpatient pharmacist will review the resident's drug regimen to verify that all appropriate medication orders have remained active.

d. If needed, the inpatient pharmacist will adjust the administration times of the transferred resident's medication orders to match the usual scheduled times of medication dosing of the receiving nursing unit, per MCM MM-27 Medication Administration.

e. The inpatient pharmacist will notify the resident's attending provider if any discrepancies are found.

5. Transfer and Return from Same Day Procedures/Appointments (i.e., not admitted to an outside facility):

a. At the time of transfer to an outside facility, nursing staff on the resident's unit will complete a trip sheet that includes a current Medication List including both scheduled and as-needed medications containing medication name, dose, route, frequency, purpose of use, and duration, if applicable.

b. The trip sheet will be transferred with the resident for review by the next provider of care.

c. The trip sheet will contain contact information for VA Butler Healthcare ROI service and/or the resident's attending provider for use by the next provider of care regarding any questions or discrepancies.

d. All medication orders for residents temporarily leaving VA Butler Healthcare for outside services or procedures will be held while the resident is temporarily away and should not be discontinued. If all medication orders for the resident are discontinued, by provider clinical judgment or in error, the admission/readmission procedures should be followed upon the resident's return to the facility. At no time are orders permitted to be blanket reinstated.

e. Upon the resident's return from the outside facility, nursing staff on the resident's unit will:

(1) Obtain any paperwork documenting medication changes or proposed medication orders and provide this information to the resident's attending provider

(2) Obtain and sequester any medications (e.g., tablets, capsules, vials, etc.) that the resident received from the outside facility.

(3) Create a brief inventory of sequestered medications, including name and strength, brought with the resident from the outside facility. If the medication is a controlled substance, a count of the quantity of the units of the controlled substance must also be noted on the inventory sheet.

(4) Provide the resident's attending provider with a copy of the inventory sheet for their review.

(5) Place the sequestered medications and the associated inventory sheet in the Medication Return Bin and store controlled substances in a locked cabinet on the nursing unit for transfer to the Police Service for destruction.

f. The provider will:

(1) Interview the resident and review all paperwork received from the outside facility.

(2) Compare the medication regimen information received from the outside facility against the active medication orders in the resident's chart.

(3) Issue medication orders, as appropriate, and document all modifications to the medication regimen in an electronic chart progress note.

g. The inpatient pharmacist will:

(1) Review all orders for appropriateness and verify new and changed medication orders for the returning resident, ensuring each order includes medication name, strength, dose, route, frequency, purpose of use, and duration.

(2) Communicate any discrepancies (including omissions, duplications, contraindications, unclear information, and changes) in the medication regimen to the resident's attending provider.

6. Transfer to an Outside Facility (i.e., admitted as an inpatient at an outside facility):

a. At the time of transfer to an outside facility, nursing staff on the resident's unit will complete a trip sheet and the provider will enter an interfacility transfer note that will include a current medication list including both scheduled and as-needed medications containing medication name, dose, route, frequency, purpose of use, and duration, if applicable.

b. The trip sheet and interfacility transfer note will be transferred with the resident for review by the next provider of care.

c. The trip sheet and/or interfacility transfer note will contain contact information for VA Butler Healthcare ROI service and/or the resident's attending provider for use by the next

provider of care regarding any questions or discrepancies.

d. All medication orders should be discontinued by the attending provider upon resident transfer. If the Veteran returns to VA Butler Healthcare, the procedure for admission/readmission will be followed.

7. Discharge:

a. Prior to discharge, the resident's provider will:

(1) Review the resident's medication orders to determine the discharge regimen.

(2) Communicate medication regimen to the resident.

(3) Provide written and/or print medication discharge instructions that include an accurate list of VA-provided discharge medications and medications to be purchased over-the-counter.

b. At discharge, the pharmacist will:

(1) Compare discharge orders with inpatient profile.

(2) Communicate with provider any discrepancies.

(3) Provide a current list of active VA discharge medications for nursing staff to review and provide to the Veteran including medication name, dose, route, frequency, purpose of use, and duration, if applicable.

c. At discharge, the nurse will:

(1) Verify discharge medications with discharge orders.

(2) Review medication discharge instructions with the resident or caregiver.

(3) Provide the resident or caregiver with an up to date medication list.

(4) Instruct the resident or caregiver to provide the list of medications to the resident's next provider of care and to notify their VA provider of any changes to their medication regimen (including herbals, over-the counter-medications, nutraceuticals, and alternative medications) occurring before their next encounter with VA clinical staff.

VI. REFERENCE: Joint Commission Medication Management and National Patient Safety Goal Standards, 2014
VHA Directive 2011-012 Medication Reconciliation

VII. RESCISSION: Medical Center Memorandum MM-29, dated June 20, 2011.

JOHN A. GENNARO
Director

(Automatic Review Date: July 1, 2017)